

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

02282

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02278

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Golt (rural)		c. LENGTH OF STAY IN lb 20-30 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS Golt (rural)	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Robert		First Robert	Middle
4. DATE OF DEATH February 19 1967		Month February	Day 19
5. SEX Male		6. MARIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. B. DATE OF BIRTH July, 20, 1912
8. AGE (In years last birthday) 54		9. IF UNDER 1 YEAR Months 	10. IF UNDER 24 HRS. Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Robert Brooks		14. MOTHER'S MAIDEN NAME Eleanor Benson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. 217-16-5734	17. INFORMANT Malinda Turner,
		Address Golts, Md. 21637	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH unknown	
4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		Known to be a heavy drinker. Had been out of home for (b) several hours. Was observed crawling home through the snow due to by his common law wife. She tried to help, was unable to do (c) so at 2:30AM. When she could get help he was dead.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Exposure and probable alcoholism		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH:		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) see above	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 2:30 2/10 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Golts		(County) Kent Co. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED Feb 19, 1967	
ACTUAL SIGNATURE <i>Robert W. Farr</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
EXAMINER'S NAME (Type) Robert W. Farr		Address (Street, city, town, or county) Golts, Md. 21637	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 21, 1967	23c. NAME OF CEMETERY OR CREMATORIUM Wesley Henry Cemetery
23d. LOCATION (City or Town) Golts, Md. 21637		(County) Kent Co. (State) Md.	
24. FUNERAL DIRECTOR Edward Fellows,		ADDRESS Millington, Md. 21651	25a. REC'D BY REGISTRAR FEB 24 1967
		25b. REGISTRAR'S SIGNATURE <i>Charles J. Hogan</i>	

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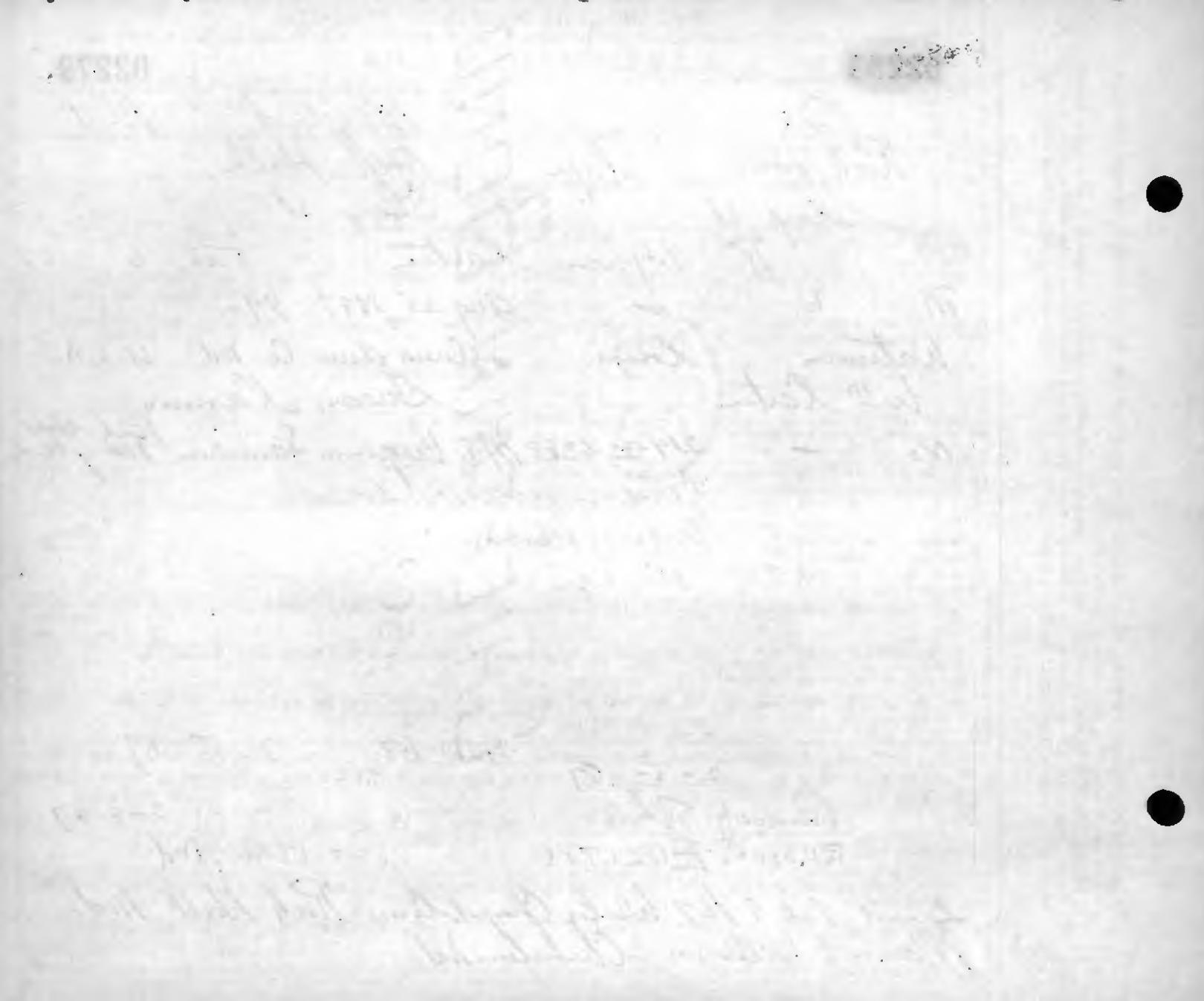
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
02278											
1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE								
Kent			Maryland								
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b								
Rock Hall			Life								
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			d. STREET ADDRESS								
Sharp St.			Shays St.								
e. IS RESIDENCE ON A FARM?											
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH	Month	Day	Year		
P. Hyson Carter					Carter	Feb. 6				1967	
5. SEX			6. COLOR DR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS			
M.			W.	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Aug 25 1887	79 yrs.	Months	Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working-life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Waterman			Comm.			Queen Anne Co. Md.			U. S. A.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME			Susan Cannon			Address		
Wm Carter									Rock Hall Maryland		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT			INTERVAL BETWEEN ONSET AND DEATH		
No			214-31-6388			Mrs. Virginia Cannon			7 days		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)											
334X											
Cerebro-vascular disease											
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.											
DUE TO (b) Arteriosclerosis											
DUE TO (c) Old age											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
21. I certify that (I) (this hospital) attended the deceased from 4-15-63 to 2-5-1967, that (I) (we) last saw the deceased alive on 2-5-1967, and that death occurred at 11:30 AM, from the causes and on the date stated above.											
22a. SIGNATURE Rudolph Sykes											
22b. DATE SIGNED 2-8-67											
22c. PHYSICIAN'S NAME (Type) RNDOLPH E GLITZ											
22d. ADDRESS Rock Hall, Md											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION (City, town or county) (State)		
Burial Feb. 9/67			Wesley Chapel Am.			Rock Hall Md.					
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Marvin L. Williams - Christian Rd.						b 14			Charles Juge		
DATE											



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **02280**

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millington		c. LENGTH OF STAY IN lb 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millington	
3. NAME OF DECEASED (Type or print) ELIZABETH		d. STREET ADDRESS	
4. DATE OF DEATH February 7, 1967		Month	Day Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH September, unknown
			9. AGE (In years last birthday) 92 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor, Retail Antique Furniture		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Dover, Del.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Timothy J. Collins.		14. MOTHER'S MAIDEN NAME Emma Benn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address Henry Ridgley Horsey, Dover, Del. 19901	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, Arteriosclerotic cardiovascular disease IMMEDIATE CAUSE (a) 422.1 Conditions, if any, which gave rise to immediate cause (b) Was found dead in her house, at about 6 AM stating the underlying cause last. DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH several years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Robert W. Farr</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Robert W. Farr, M. D.		DATE SIGNED 2/9/67	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 11, 1967	
22c. NAME OF CEMETERY OR CREMATORIUM Lake Side Cemetery.		22d. LOCATION (City, town, or county) (State) Dover, Kent Co; Del.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edward Gillow</i>		ADDRESS Millington, Md. 21651	
24a. REC'D BY REGISTRAR FEB 14		24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with registrar prior to burial, cremation, or removal.

WELLINGBOROUGH CEMETERY - GRAVE

100-3

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02285

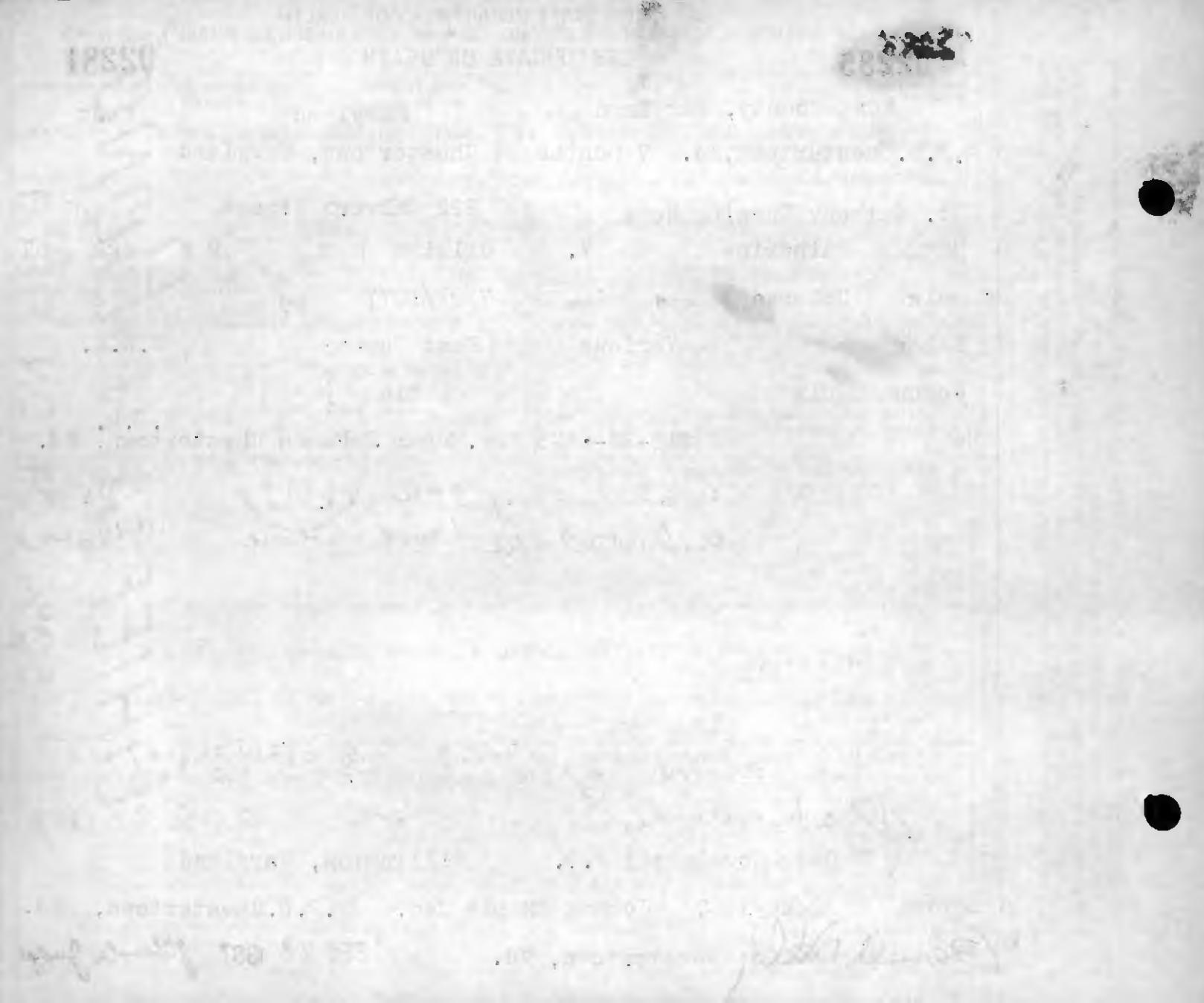
CERTIFICATE OF DEATH

02281

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Kent County, Maryland MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b R.F.D. Chestertown, Md. 7 Months		a. STATE	b. COUNTY
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		St. Anthony Nursing Home		Maryland Kent	
3. NAME OF DECEASED (Type or print)	First Catherine	Middle V.	Last Gilliam	4. DATE OF DEATH Month 2	Day 22 Year 67
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/21/1877	9. AGE (In years last birthday) 89 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Various	11. BIRTHPLACE (County & State, or foreign country) Kent County		12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME Joshua Caulk		14. MOTHER'S MAIDEN NAME Katie			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-20-4475	17. INFORMANT Mrs. Edgar Johnson Chestertown, Md.	Address R.F.D.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Aortic coronary occlusion</i> <i>4201</i> Conditions, If any, which gave rise to immediate cause (a), stating (b) <i>Arteriosclerotic heart disease</i> underlying cause last. DUE TO DUE TO (c) <i>15 min.</i> <i>10 years</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.)	20f. (City or town) (County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <i>Nov. 7, 1966</i> , to <i>Feb. 22, 1967</i> , that (I) (we) last saw the deceased alive on <i>Febr. 14, 1967</i> , and that death occurred at <i>10 P.M.</i> from the causes and on the date stated above.					
22a. SIGNATURE <i>Geza Koralewski</i>		22b. DATE SIGNED <i>2.24.1967</i>			
22c. PHYSICIAN'S NAME (Type) Geza Koralewski		M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/26/1967	23c. NAME OF CEMETERY OR CREMATORY Joshua Chaple Cem.	23d. LOCATION (City, town or county) R.F.D. Chestertown, Md.	
24. FUNERAL DIRECTOR <i>Zemel Walker</i>		ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR DATE FEB 28 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **02282**

1. PLACE OF DEATH a. COUNTY Kent		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Galena		c. LENGTH OF STAY IN lb		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Kent	
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Galena			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First ROLAND	Middle E.	Last HANIFEE	4. DATE OF DEATH Month Feb	Day 4	Year 1967
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October, 29, 1915	9. AGE (In years last birthday) 51 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Labor	10b. KIND OF BUSINESS OR INDUSTRY Farming.	11. BIRTHPLACE (State or foreign country) Md.	12. CITIZEN OF WHAT COUNTRY? USA
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13. FATHER'S NAME William Hanifee.	14. MOTHER'S MAIDEN NAME Anna Tibbitt.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.	16. SOCIAL SECURITY NO. 213-18-4215	17. INFORMANT Mr. Hubert Hanifee, Kennedyville, Md. 21645	Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		?
DUE TO Alcoholism and Exposure ?		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		
(b) Was an alcoholic, and had been drinking heavily lately. Was seen lying on the back porch of an abandoned house at about 11:30AM, & was found dead there at about 3:40PM, both times on the day of death. Had not been known to be otherwise in poor health.		
DUE TO		
(c) see above		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Blood drawn for toxicological and alcohol determinations		

20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) see above	20c. TIME OF INJURY Month, Day, Year Hour a. m. Feb 4 67 p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Galena	20f. (City or town) Galena	(County) Kent	(State) Md.
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21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
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ACTUAL SIGNATURE <i>Robert W. Farr</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED Feb 4., 1968
EXAMINER'S NAME (Type) Robert W. Farr, M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial.	22b. DATE THEREOF Feb. 7, 1967	22c. NAME OF CEMETERY OR CREMATORIUM Galena Cemetery.	22d. LOCATION (City, town, or county) Galena, Kent Co, Md.	(State)
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23. FUNERAL DIRECTOR'S SIGNATURE <i>Edward Fellow</i>	ADDRESS Millington, Md.	24a. REC'D BY REGISTRAR FEB 9	24b. REGISTRAR'S SIGNATURE <i>Judge</i>
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THE STATEMENT OF THE
AMERICAN EGYPTIAN COUNCIL OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

information from birth cert.

CERTIFICATE OF DEATH

02283

1 PLACE OF DEATH o COUNTY Kent		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o STATE Md.	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kent End Queen Anne's Hosp.		d STREET ADDRESS R# 2 Hatland Rd.		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print)	Twin II	First	Middle	3. DATE OF DEATH	Month Day Year
SEX	Female	6 COLOR OR RACE W	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-16-67	9 AGE (In years last birthday) yrs. Months Days Hours Min.
10a J.S. & J.L. OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Chesilston Kent Co. Md.	
13. FATHER'S NAME Paul Albert Hastings Jr.		14. MOTHER'S MAIDEN NAME Brenda Charlene Kempfield		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN J.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fatal at alee & sasi DUE TO 7630 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Was second delivery of Racketton - by C-section					
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 2-16-67, to 2-18, 1967, that (I) (we) last saw the deceased alive on 2-18-1967, and that death occurred at 10:03 P.M. from causes and on the date stated above					
22a SIGNATURE Robert W. Farr		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c PHYSICIAN'S NAME (Type) Robert W. FARR		22d ADDRESS Chesilston, Md.		22b. DATE SIGNED 2-19-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-19-67		23c. NAME OF CEMETERY OR CREMATORIAL Chester Cemetery	
24. FUNERAL DIRECTOR Marvin L. Williamson Chesilston, Md.		ADDRESS		23d. LOCATION (City or Town) (County) (State) Chesilston Kent Co. Md.	
25a. REC'D BY REGISTRAR FE 15 23 1967				25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours, after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02288

CERTIFICATE OF DEATH

02284

1. PLACE OF DEATH a. COUNTY		Kent County, Maryland MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE		Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b R.F.D. Chestertown, Md. 4 Yrs.		b. COUNTY		Kent		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		At the home of his Son		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Rock Hall, Maryland		
3. NAME OF DECEASED (Type or print)		First James	Middle 	Last Hopkins	4. DATE OF DEATH	Month 2	Day 3	Year 1967
5. SEX Male		6. COLOR OR RACE Colored	7. MARRIED WIDOWED +	NEVER MARRIED DIVORCED	8. DATE OF BIRTH 10/10/1888	9. AGE (In years last birthday) 78 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Various		11. BIRTHPLACE (County & State, or foreign country) Kent County, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Samuel Hopkins		14. MOTHER'S MAIDEN NAME Caroline Thompson						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. No 217-30-8009		17. INFORMANT Mr. Melvin Hopkins Chestertown, Md.		Address R.F.D.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-vascular disease		INTERVAL BETWEEN ONSET AND DEATH same day				
		DUE TO (b) Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO (c) Arteriosclerosis Old age.					
20a. MEDICAL CERTIFICATION		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Rock Hall, Maryland	(County) Kent	(State) Md.	
21. I certify that (I) (this hospital) attended the deceased from once in 1965 to 19, that (I) (we) last saw the deceased alive on June 1965, and that death occurred at 6 A.M. from the causes and on the date stated above.				22b. DATE SIGNED				
22a. SIGNATURE Rudolfs Eglitis				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
22c. PHYSICIAN'S NAME (Type) Rudolfs Eglitis M.D.		22d. ADDRESS Rock Hall, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/7/1967		23c. NAME OF CEMETERY OR CREMATORIAL Aaron Chaple Cem.		23d. LOCATION (City, town or county) (State) R.F.D. Rock Hall, Kent Md.		
24. FUNERAL DIRECTOR Bennett Kelly		ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR FEB 10 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		



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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02289

CERTIFICATE OF DEATH

02285

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Kent		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a. COUNTY Maryland		b. COUNTY Kent					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b 15 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kent & Queen Anne's Hospital				e. STREET ADDRESS 351 Calvert Street		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
g. NAME OF DECEASED (Type or print) Beatrice		First	Middle	Lost	4. DATE OF DEATH Johnson	Month 2	Day 15	Year 1967			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/4/1890	9. AGE (In years last birthday) 76 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. Hours 0	13. Min 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPL. ACE (County & State, or foreign country) Kent Co., Maryland		12. CITIZEN OF WHAT COUNTRY? US					
13. FATHER'S NAME Andrew		14. MOTHER'S MAIDEN NAME C. ann		15. INFORMANT Catherine		16. Address Lively					
17. IS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service No		18. SOCIAL SECURITY NO. YES		19. INFORMANT Hospital Records		20. INTERVAL BETWEEN ONSET AND DEATH 24 hours					
21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4/201		Coronary Thrombosis							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b)	Arteriosclerotic C.V. Disease		unknown						
		DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)		
21. I certify that (I) (this hospital) attended the deceased from 2/14 , 1967, to 2/15 , 1967, that (I) (we) last saw the deceased alive on 2/15 , 1967, and that death occurred at 9:03 A.M. from causes and on the date stated above.											
22a. SIGNATURE <i>Ruth Steen</i>		22b. DATE SIGNED 2/16/67									
22c. PHYSICIAN'S NAME (Type) Dr. R. W. Farr		22d. ADDRESS Chestertown, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) Bur. A.		23b. DATE THEREOF 2/18/67		23c. NAME OF CEMETERY OR CREMATORIAL JANE CEMETERY		23d. LOCATION (City or Town) Chestertown Kent, Md		(County)		(State)	
24. FUNERAL DIRECTOR Garnett Waller		ADDRESS CHES/ERTOWN MD		25a. REC'D BY REGISTRAR DATE FEB 23 1967		25b. REGISTRAR'S SIGNATURE Charles J. Jones					



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02290

CERTIFICATE OF DEATH

02286

1. PLACE OF DEATH a. COUNTY Kent MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN lb 56 Days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sudlersville		17-1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kent and Queen Anne's Hospital			d. STREET ADDRESS None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Herbert Esterbrook		First Middle Parker	Lost	4. DATE OF DEATH February 27 1967	Month Doy Year
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/29/91	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pharmacist - Retired			10b. KIND OF BUSINESS OR INDUSTRY Drug Store		11. BIRTHPLACE (County & State, or foreign country) Colorado
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WWI - WWII		16. SOCIAL SECURITY NO. 579-40-7404	17. INFORMANT Address Hospital Records Chestertown		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1992 Generalized carcinoma of colon. ? DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ DUE TO lost. (c) _____ DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/2 , 1967, to 2/27, 1967, that (I) (we) last saw the deceased alive on 2/27 1967, and that death occurred at M, from causes and on the date stated above.					
22a. SIGNATURE <i>Dr. A. C. Dick</i>		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 2-22-67
22c. PHYSICIAN'S NAME (Type) Dr. A. C. Dick			22d. ADDRESS Chestertown, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar. 2, 1967	23c. NAME OF CEMETERY OR CREMATORIUM Sudlersville Cemetery.	23d. LOCATION (City or Town) (County) (State) Sudlersville, Q.A.C.O.; Md.	
24. FUNERAL DIRECTOR Edward Fellows,			ADDRESS Millington, Md. 21651	25a. REC'D BY REGISTRAR DATE MAR 3 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

02291

CERTIFICATE OF DEATH

02287

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS Rock Hall	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ida		First May	Middle Staats
4. DATE OF DEATH February 14 1967		Last Staats	Month February Day 14 Year 1967
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH July 15, 1877		9. AGE (in years last birthday) 89 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Dieringer		14. MOTHER'S MAIDEN NAME Adeline Perego	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Cardio-vascular disease	
DUE TO (b) Arteriosclerosis and hypertension		10 days	
DUE TO (c) old age			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from now , 1963, to 2-14 , 1967, that (I) (we) last saw the deceased alive on 2-13-1967 , and that death occurred at 5:20 M, from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE Rudolfs Eglitis		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) Rudolfs Eglitis M.D.		22d. ADDRESS Rock Hall, Maryland 2-16-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL Feb. 17		23b. DATE THEREOF Feb. 17	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Wesley Chapel
24. FUNERAL DIRECTOR Edgar L. Lane		ADDRESS Church Hill, Md.	25a. REC'D BY REGISTRAR FEB 21 1967
			25b. REGISTRAR'S SIGNATURE Charles Judge

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